CHAPTER 3
SECTION 1.5

DEERS FUNCTIONS

1.0.   As the centralized data repository of DoD personnel and medical data and the National Enrollment Database (NED) for the portability of the MHS worldwide TRICARE program, the DEERS is designed to provide benefits eligibility and entitlements, TRICARE enrollments and claims coverage processing.

This chapter will detail the events to verify eligibility, perform enrollments, assign a Primary Care Manager (PCM), transfer enrollments, perform a claims inquiry, and the associated updates of address information, Catastrophic Cap and Deductible (CC&D) information, Other Health Insurance (OHI) and the Standard Insurance Table (SIT). The expected data stores for the MCSC are illustrated in Figure 3-1.5-1. Deviation from the intended concept of operations between the MCSC and DEERS shown in the figure below is at the contractors technical and financial risk.

1.1.   **Partial Match**

DEERS provides two views of benefits and entitlements information: Eligibility for Enrollment and Coverage. [NOTE: The Eligibility for Enrollment view is provided through the DOES application only.] Both views of eligibility may result in a partial match situation due to person ambiguity. Person ambiguity can occur when two or more persons have the same SSN within DEERS. As mentioned previously with multiple entitlements, a person's role within DEERS may change over time, meaning he or she may be both a family member and a sponsor. Therefore, DEERS uses the Person Type Code (sponsor or family member) to identify the role the person is representing in the family. If the request uses the SSN of the sponsor, DEERS conducts the search where the SSN is used for a person representing a sponsor. If DEERS determines that the SSN is associated with multiple sponsors, DEERS provides a partial match response.

Likewise, if the request uses the SSN of a family member, DEERS conducts the search where the SSN is used for a person representing a family member. If DEERS determines that the SSN is associated with multiple family members, DEERS provides a partial match response.

If there is ambiguity, then a partial match response is returned. There will be a separate listing for each person or family matching the requested SSN. The listing includes the sponsor and family member identification information needed to determine the correct beneficiary or family including the DEERS ID, the Patient ID, or possibly both. The requesting organization must select which of the multiple listings is correct based on documents or information at hand. After this selection, the requesting organization would use the DEERS ID or Patient ID of the person or family chosen to send the inquiry. A partial match response may be returned for any inquiry that does not use a DEERS ID or Patient ID.

If the request uses the DEERS ID or the Person ID, DEERS identifies the individual positively and returns the requested information. Using the DEERS ID in an inquiry always provides an unambiguous match.

1.2.   Health Care Delivery Program Eligibility and Enrollment

The rules for determining a beneficiary's entitlement to health care benefits are applied by rules-based software within DEERS. DEERS is the sole repository for these DoD rules, and no other eligibility determination outside of DEERS is considered valid. Whenever data about an individual sponsor or a family member changes, DEERS reapplies these rules. DEERS receives daily, weekly, and monthly updates to this data, which is why organizations must query DEERS for eligibility information before taking action. This insures that the individual is still eligible to use the benefits and that the MCSC or the USFHP provider has the most current information.

A beneficiary who is considered eligible for DoD benefits, according to DoDI 1000.13, is not required to "sign up" for the TRICARE Standard benefits or any other DEERS assigned plan. If an authorized organization inquires about that beneficiary's eligibility, DEERS reflects if he or she is eligible to use the benefits. The effective and expiration dates for assigned plan coverage are derived from DoDI 1000.13 rules and supporting information.

1.2.1.   Enrollment-Related Business Events

- Enrollment related business events include:

- Eligibility for enrollment identifies current enrolled coverage plans and eligibility for enrollment into other coverage plans

- New enrollments are used for enrolling eligible sponsors and family members into HCDP coverage plans or for adding family members to an existing family enrollment. Enrollments begin on the date specified by the enrolling organization and extend through the beneficiaries' end of eligibility for the HCDP. New enrollments may also perform the following functions:

  - Specify enrollment fee information
  - PCM selection
  - Update address, email address and/or telephone number
  - Record that the enrollee has other health insurance (OHI)
  - Request an addition or update to the Standard Insurance Table (SIT)

- Modifications of the current enrollment (updates) are used to change some information in the current enrollment plan. Modifications of the current enrollment include the following functions:

  - Change or cancel a PCM selection
  - Transfer enrollment (enrollment portability) or cancel a transfer
  - Change enrollment begin date
  - Cancel enrollment/disenrollment

- Individual fee waiver information is used to indicate that an enrollee is exempt from paying enrollment fees.

- Enrollment fee payments and enrollment fee exceptions are used to indicate payment of, or exception from payment of, enrollment fees. The enrollment fee history transaction is used to view this detailed information for a specified policy.

- Disenrollments are used to terminate the specified beneficiary's enrollment. Disenrollments are used for disenrolling a beneficiary only when he or she has lost eligibility, voluntarily disenrolls (e.g., chooses not to re-enroll) or involuntarily disenrolls (e.g., fails to pay enrollment fees).

- Modifications to a previous enrollment (updates) are used to change some information in the previous enrollment plan. Modifications of the previous enrollment include the following functions:

  - Change enrollment end date
  - Change enrollment end reason

- Request an enrollment card replacement

- Add, update, or cancel OHI information for an enrollee

- Add, update or cancel SIT entries

The following figure shows the data and process flow required by the Government. Deviations from this diagram are at the contractor's technical and financial risk.

FIGURE 3-1.5-1   DEERS ENROLLMENT AND CLAIMS INTERACTION
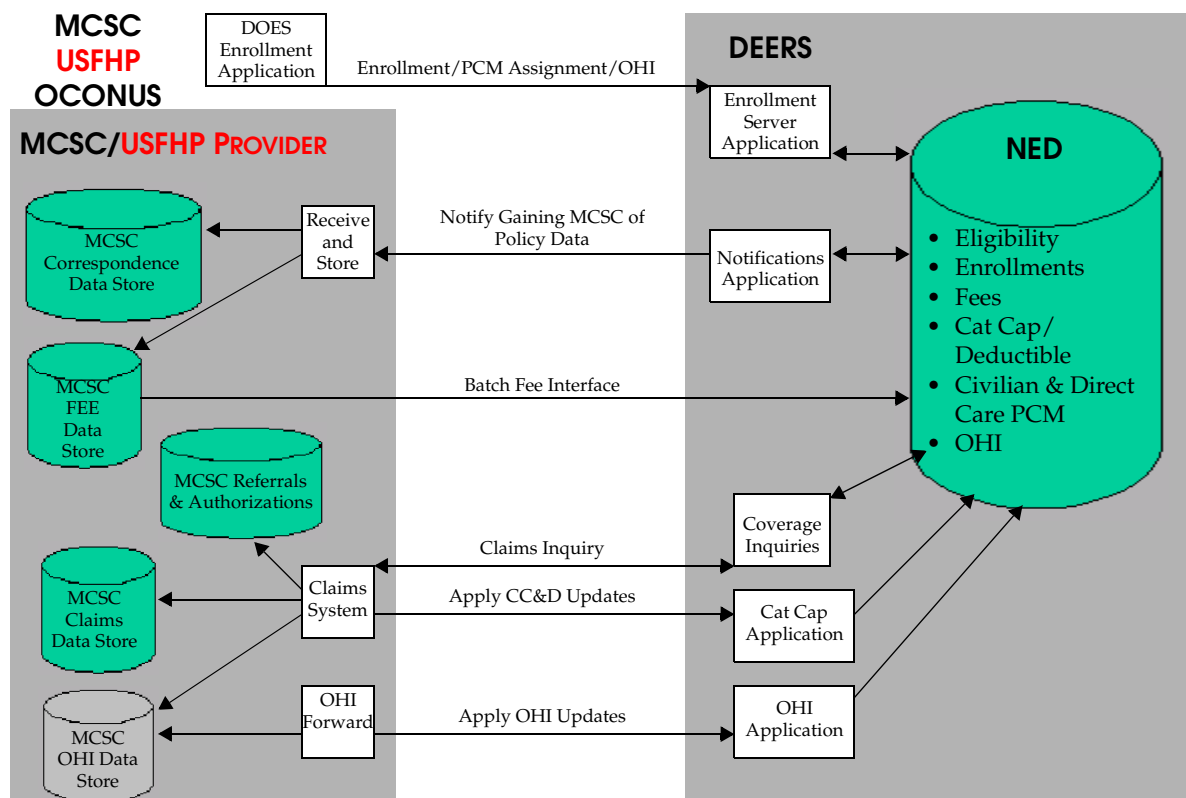
1.2.2. **Defense Online Eligibility and Enrollment System (DOES)**

DOES is a full function GFE application developed by DMDC to support enrollment-related activity and research. DOES interacts with both the main DEERS database as well as the NED satellite database to provide enrolling organizations with eligibility and enrollment information, as well as the capability to update the NED with new enrollments and modifications to existing enrollments. MCSCs and USFHP providers are required to perform enrollment related functions through DOES, including:

- Enrollment
- Disenrollment
- PCM Change
- PCM Cancellation and Transfer Cancellation
- Transfer
- Enrollment Period Change
- Enrollment End Reason Code Change
- Enrollment/Disenrollment Cancellation
- Enrollment Fee Payment (initial fee payment upon enrollment only)
- Enrollment Fee Waiver Update for an Individual
- Beneficiary Update
- Standard Insurance Table (SIT) Add, Update or Cancel Request
- Other Health Insurance (OHI) Add
- Other Health Insurance (OHI) Update
- OHI cancel

The DOES application meets HIPAA guidelines for a direct data-entry application, and is data-content compliant for enrollment and disenrollment functions.

Refer to Addendum F for the National Enrollment Database DOES Training document for examples of screens for DOES.

1.2.3. **Beneficiary Self-Service**

DEERS also provides a web application for the beneficiary to perform enrollment-related activities. The web application will include all of the data elements contained on the Office of Management and Budget (OMB) approved universal enrollment/PCM change form. The beneficiary can perform an enrollment, PCM change, address update, transfer of enrollment, disenrollment, limited cancellation events, or a request for a new enrollment card. This application services the Active Duty population and their family members. The MCSC or USFHP provider shall acknowledge, within the National Enrollment Database, all beneficiary web enrollments within two business days of receipt of the web enrollment. The MCSCs and USFHP providers shall consider beneficiary provided data on the enrollment web application as having the same validity as beneficiary provided data on paper enrollment forms.

The beneficiary self-service solution allows MCSCs or the USFHP providers to brand the application and customize the layout of each page. DEERS will not provide support or interfaces to MCSC web applications that perform any enrollment-related functions.

The following descriptions provide an overview of each enrollment-related business event.

1.2.4.   Eligibility for Enrollment

The DoD provides assigned health care delivery programs and plans when a person joins the DoD. DEERS determines coverage plans for which a beneficiary is eligible to enroll by using the DoD-assigned coverage in conjunction with additional eligibility information. The Eligibility for Enrollment Inquiry in DOES is used to view a person's or family's eligibility to enroll. [NOTE: The Eligibility For Enrollment Inquiry in DOES should not be used for other eligibility determinations. For example, Designated Providers should use GIQD and not DOES to determine if a person is eligible for a hospital admission.]

DEERS provides coverage plan information identifying the period of eligibility and/or enrollment for the coverage plan. A beneficiary can only be enrolled into the coverage plans that have an "eligible for" status. Refer to Chapter 3, Addendum C, HCDP Plan Coverage Details, for additional information on the coverage plans a beneficiary is eligible for based on the DEERS assigned coverage.

When a sponsor and family member are first added into DEERS, DEERS determines basic eligibility for health care benefits based on DoDI 1000.13 and establishes an assigned HCDP coverage plan together with coverage dates.

For example, when an active duty sponsor and family members are added to DEERS:

- A sponsor is assigned a Direct Care for Active Duty Sponsors plan in which he or she is the subscriber and the insured with direct care entitlement only. The dates on the coverage represent the dates determined by the eligibility rules.

- A sponsor with family members is listed as the subscriber under the TRICARE Standard for Active Duty Family Members assigned plan. The sponsor is not insured under this coverage plan.

- Eligible family members are assigned a TRICARE Standard for Active Duty Family Members plan as insured with both direct care and civilian health care coverage. The coverage plan dates are determined by the eligibility rules. There are no enrollment dates, since this option requires no enrollment.

1.2.5.   Enrollment

The assigned plans provide the foundation for enrollment into various coverage plans. Enrollments cannot span multiple assigned plans.

Enrollments are at the individual or family level, depending on the number of family members wishing to enroll. DEERS allows one family member to enroll in a family plan, but does not allow more than one family member to enroll in an individual plan when a family plan is available. DEERS automatically switches enrollment plans from individual to family upon the enrollment of a second family member; however, DEERS does not make automatic adjustments from family to individual plans upon the disenrollment of all but one

family member. It is the MCSC's or USFHP provider's responsibility to make such changes via DOES. Some HCDP's, such as TRICARE Plus, only offer enrollment on an individual basis, and there is no family option. For these plans, DEERS does not limit the number of individual plans that a family may have.

The MCSC or USFHP provider is required to enter the following information into DOES in order to complete an enrollment:

- Coverage plan

- Enrollment begin date (if different than DOES default)

- PCM assignment

  - PCM Network Provider Type Code (if not defaulted by DOES)

  - PCM Enrolling Division (if more than one is available for the coverage plan and PCM Network Provider Type Code)

  - Individual PCM selection

Restrictions on use and limits on how far an enrollment can be backdated are addressed in the Chapter 3, Addendum D, Medical Business Rules and the TRICARE Policy Manual.

Enrollment anniversary dates for all enrollees are being transitioned to a fiscal year basis, i.e., October 1 through September 30. To accomplish this, on new enrollments or when a policy is up for renewal, the MCSC shall only establish the policy and prorate the enrollment fees through the end of the current fiscal year. At the end of that fiscal year, the MCSC shall renew the policy for the next fiscal year. MCSCs shall be responsible for accommodating enrollment periods that are not aligned with the fiscal year for transitioned and transferred policies until their renewal date.

The following figure illustrates the process of system interactions for enrollments and enrollment updates:

FIGURE 3-1.5-2   ENROLLMENT PROCESS
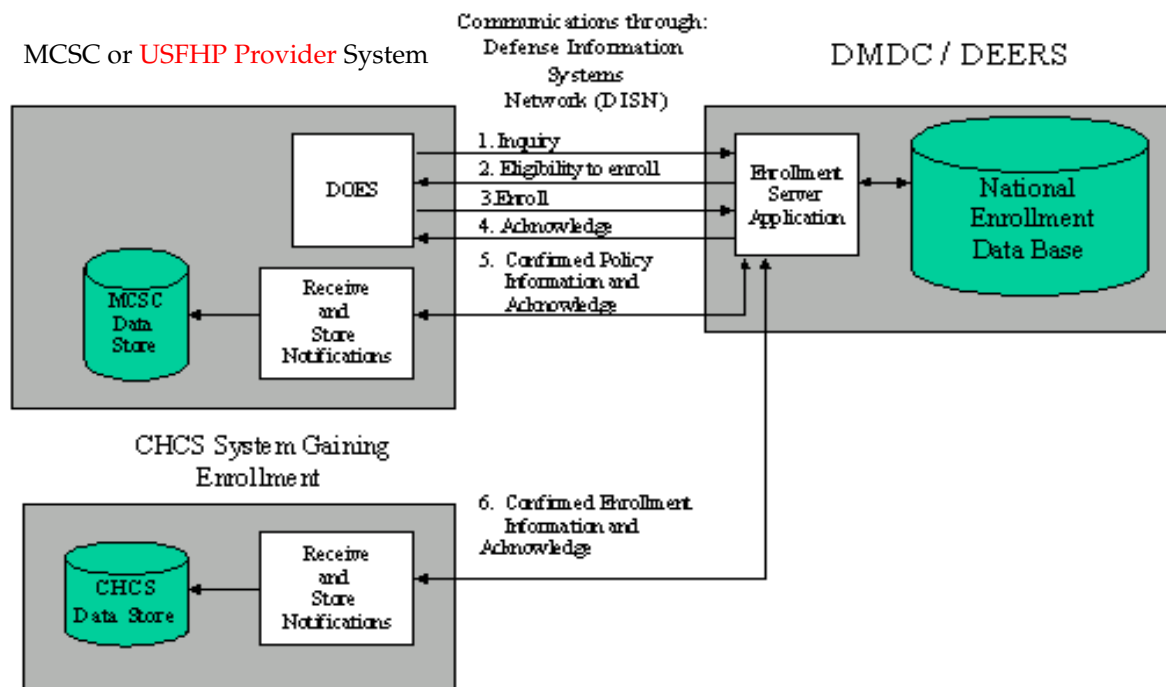
1.2.5.1.   PCM Assignment Within The DOES Application

DEERS has a centralized PCM file containing all MCSCs' civilian network PCMs and PCMs for the Direct Care and USFHP provider systems. Additions, modifications, deletions and deactivations, and reactivations of PCMs must be performed in the MCSC provider system, and the USFHP provider system. The MCSCs and USFHP providers shall provide daily additions, modifications, deactivations, and reactivations on their provider files for retrieval by DEERS. If an MCSC or USFHP provider sends a deactivation for a PCM, DEERS inactivates the PCM from the central file. MCSCs and USFHP providers cannot reuse PCM Ids as they deactivate or delete PCMs from their provider system. DEERS will not allow subsequent assignments to a deactivated PCM. A reactivation of a PCM reinstates the provider with no gap in the time that enrollees can be assigned as opposed to sending another addition to DEERS for that provider which would include a new effective date for assignment.

The DOES application accesses the central PCM file to perform provider assignments. DOES has incorporated logic to search for providers using at least one of the following combinations and returns all PCM records matching the criteria:

a   PCM ID, PCM Name (no wildcards)
b   PCM Group Name (no wildcards)
c   PCM ZIP Code (entire ZIP Code or the first 3 digits only)
d   PCM City, PCM State

     e   PCM Specialty, PCM ZIP Code (entire ZIP Code or the first 3 digits only)
     f   PCM Specialty, PCM City, PCM State
     g   PCM Gender, PCM Zip Code (entire ZIP Code or the first 3 digits only)
     h   PCM Gender, PCM City, PCM State
     i   DMIS ID (for Direct Care PCMs)

1.2.5.2.   **Direct Care PCM Assignment**

     The MCSC shall perform Direct Care PCM assignment at the time of enrollment in the DOES application. The MCSC shall use the PCM preference indicated on the enrollment form in addition to guidance contained in any MOU agreement or other government-provided direction, if available. If the enrollment form contains a specialty or gender preference, the MCSC shall use the preference filters available in DOES to select a PCM. In the case where a beneficiary has not indicated a preference and there is not precise direction in an MOU or other government direction, DOES will default a PCM. DOES will only display PCMs with available capacity in the selected DMIS-ID. The MCSC is responsible for determining the appropriate DMIS-ID based on MOUs, access standards, andy any specific guidance from the government. If there is no capacity at a Direct Care facility, the MCSC shall assign the beneficiary to the civilian network.

1.2.6.   **Disenrollment**

     Once actively enrolled in a coverage plan, an individual or family may voluntarily disenroll or be involuntarily disenrolled. Voluntary disenrollment is self-elected. Involuntary disenrollment occurs from failure to pay enrollment fees or from loss of eligibility. Upon disenrollment, DEERS will send a letter to the beneficiary informing the beneficiary of the change in or loss of coverage. DEERS will send a daily file to the MCSC/USFHP provider identifying beneficiaries for whom disenrollment letters were sent.

1.2.6.1.   **Disenrollment - Loss Of Eligibility**

     A loss of eligibility includes both a loss or change in eligibility for: 1) DoD health care benefits according to the current DoDI 1000.13; or 2) an individual health coverage plan. Under these circumstances, DEERS terminates any current enrollment or cancels an enrollment effective at a future date. DEERS sends an unsolicited disenrollment notification when loss of eligibility occurs.

     Because DEERS reapplies its rules-based logic each time benefits determination data about a sponsor or family member changes, certain events may trigger disenrollment.

     For example, when the sponsor's eligibility terminates, such as upon separation from service at an earlier date than expected, this terminates the assigned coverage for the entire family. The termination of assigned coverage affects the insureds' enrollment information; therefore DEERS terminates their current enrollments and/or cancels future enrollments into an HCDP. Unsolicited disenrollment transactions are sent to the necessary systems notifying them of the termination of coverage benefits.

Since enrollments extend through the end of eligibility, DEERS does not send notifications for projected loss of eligibility communicated at the time of enrollment. The MCSC/USFHP provider systems must accommodate future end dates for policy and PCM.

There may be instances where DEERS receives notice of a loss of eligibility from the Uniformed Services, only to later be informed of the immediate reinstatement. Upon the receipt of the initial loss of eligibility, DEERS terminates the enrollment. Upon receipt of the notice of reinstatement, DEERS reinstates the eligibility and enrollment as long as there are no gaps in eligibility. In cases where eligibility changes based on a change to the sponsor's affiliation with a DoD organization, DEERS will terminate any enrollment associated to the previous eligibility segment, but will not automatically enroll beneficiaries for the new eligibility segment. The most common example of this is when a service member retires. The loss of eligibility for TRICARE for active duty service members will terminate the individual's enrollment in that program. No enrollment for TRICARE for retired sponsors and family members will be generated.

1.2.6.2.   Disenrollment - Voluntary

An insured may choose to terminate his or her current enrollment prior to the end date, or choose not to re-enroll into the current coverage plan. This transaction is performed in DOES. DEERS then terminates the coverage plan for the insured and reverts to the DEERS-assigned coverage, starting on the day after the termination of the previous enrollment. If additional systems need notification of the disenrollment, DEERS sends disenrollment notifications as necessary, notifying them of the termination of coverage benefits.

1.2.6.3.   Disenrollment - Involuntary

The subscriber may fail to pay enrollment fees. In this case, the enrolling organization performs a disenrollment with a reason code of "failure to pay fees". Individuals who are waived from paying enrollment fees are not disenrolled because of this exemption from enrollment fee payments. Disenrollment for failure to pay fees is either performed in DOES or through a batch 'disenrollment for failure to pay fees' system to system interaction.

When there is a disenrollment, the appropriate systems are notified, as necessary.

1.2.7.   Modification Of Enrollment

There are several reasons to modify an enrollment:

- Change or cancel a PCM selection
- Transfer enrollment (enrollment portability) or cancel a transfer
- Change enrollment begin or end date
- Change enrollment end reason
- Cancel enrollment/disenrollment

When there is a modification to an enrollment, the appropriate systems are notified, as necessary.

1.2.7.1.   PCM Change And Cancellation

PCM reassignments occur when the enrollee changes regions, or desires to change PCM's within the region or MTF. An enrollee changes PCMs by completing a PCM change request form and submitting the change request to the MCSC, which makes the change via DOES. Only the current enrolling organization may change the PCM selection. A PCM change can occur at any time during an active or future enrollment; however, the effective date for the new PCM must fall within the defined business rules (see Chapter 3, Addendum D). DEERS terminates the previous PCM with an end date, which will be the day before the begin date for the new PCM. Upon change of PDM, DEERS will send a letter to the enrollee notifying the enrollee of the new PCM information. DEERS will send a daily file to the MCSC/USFHP provider identifying beneficiaries for whom PCM change letters were sent.

A PCM cancellation may be performed for the enrollment's most current PCM assignment and can only be performed in the DOES application. Cancellation of a PCM change can only be performed by the enrolling organization responsible for managing the enrollment, and must be performed within the time period specified in the business rules (see Chapter 3, Addendum D). When canceling a PCM, the enrolling organization may reinstate the previous PCM, or choose to select a new PCM to replace that being cancelled. There can be no date gaps between PCM selections for plans that require a PCM. DOES will decrement and increment PCM capacities as PCM changes and cancellations are performed.

DOES will allow PCM's with available capacities to be assigned as new PCM's. If a MCSC is canceling a PCM assignment, DOES will permit reinstatement of a PCM whose capacity has been reached. Only a warning in DOES will be provided in this case.

1.2.7.2.   PCM Panel Reassignment

DMDC provides a Civilian PCM Panel Reassignment application to allow MCSCs and USFHP providers to perform mass reassignments of a PCM's enrollees. Within a MCSC or a USFHP provider, a MCSC or USFHP provider may move a Civilian PCM's entire panel to a new Civilian PCM.

The reassignments selected by the MCSC are processed nightly by DEERS. As the PCM reassignments are processed, DEERS sends notifications to the appropriate systems. DEERS will decrement and increment PCM capacities as necessary, but will not prevent the reassignment if the selected PCM does not have available capacity.

FIGURE 3-1.5-3   PCM ASSIGNMENT PROCESS

FIGURE 3-1.5-3   PCM ASSIGNMENT PROCESS
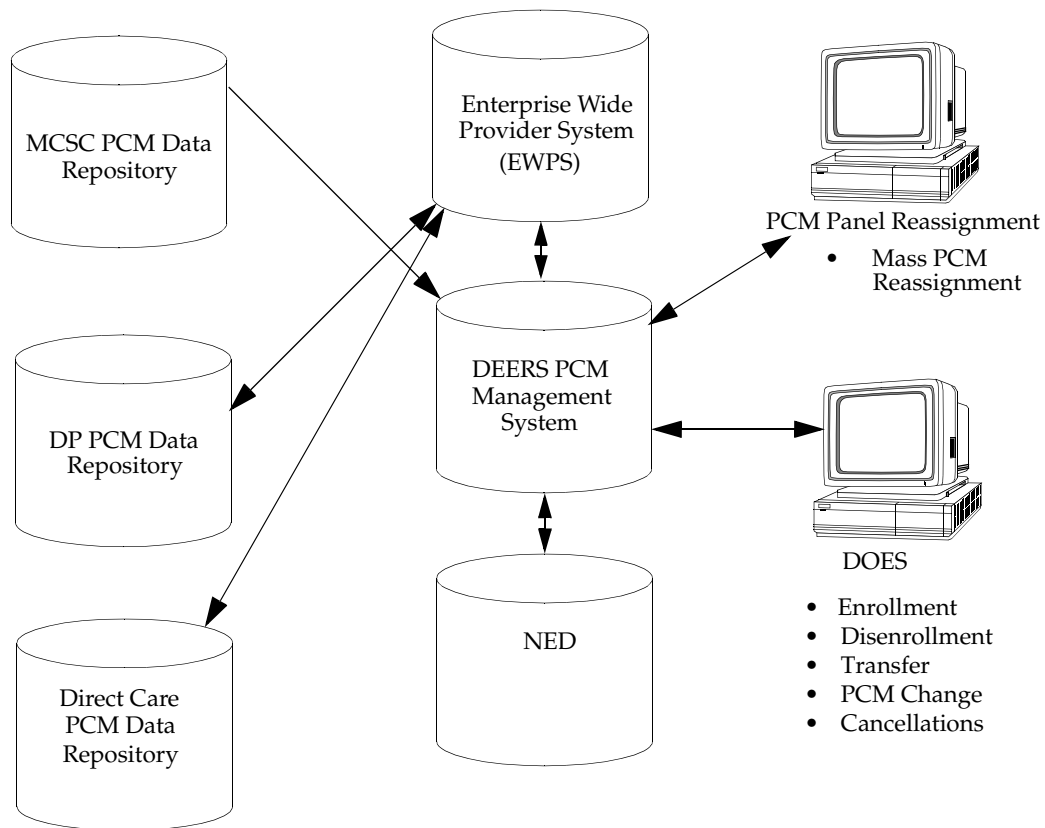
1.2.7.3.   Transfer Of Enrollment And Transfer Cancellation

A transfer of enrollment moves the enrollment from one contract to another and thus moves the responsibility for the administration of the enrollment to the gaining contractor. DEERS supports transfers among coverage plans within an HCDP (e.g., TRICARE Prime). Portability does not exist between most HCDPs (e.g., TRICARE Prime and TRICARE Plus). If a beneficiary is enrolled in TRICARE Prime and wishes to enroll into TRICARE Plus or vice versa, upon moving to a new enrolling organization's region, a transfer of enrollment is not applicable. A disenrollment from TRICARE Prime with the previous contractor and a new enrollment into TRICARE Plus must be established with the new contractor. See Chapter 3, Addendum D, Medical Business Rules, for limitations regarding transfer and transfer cancellation transactions.

FIGURE 3-1.5-4 ENROLLMENT TRANSFER PROCESS
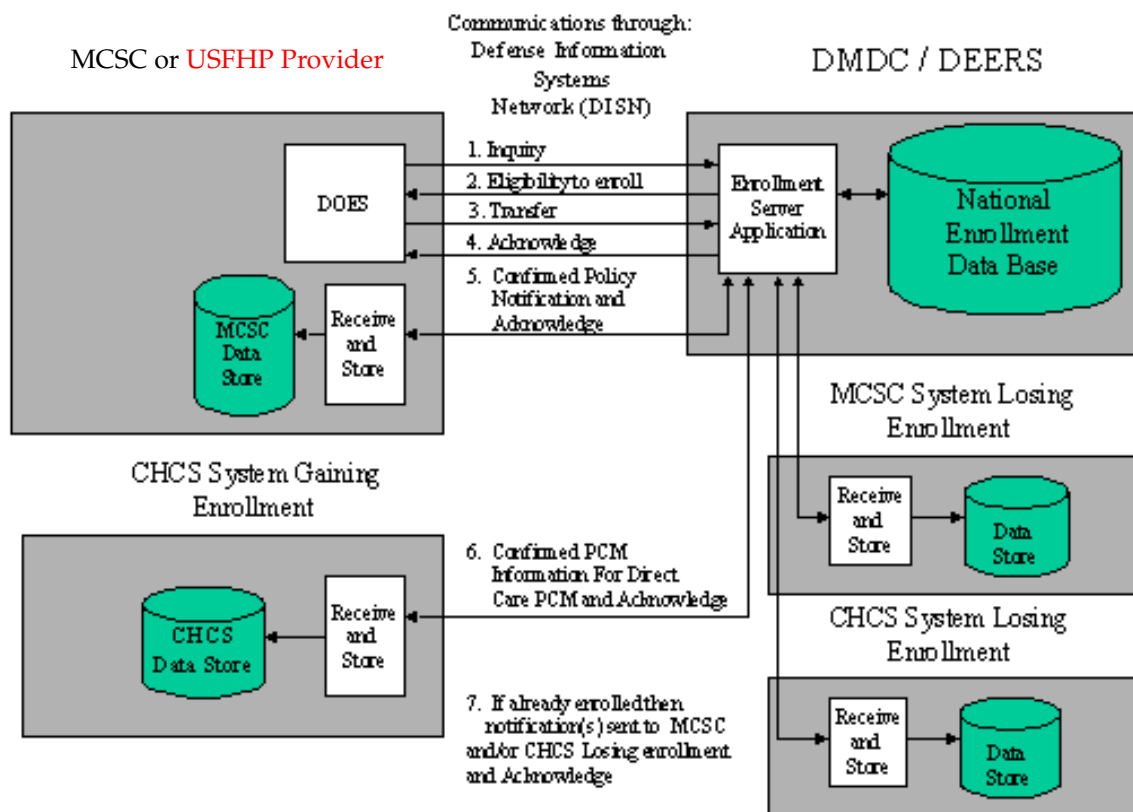
If an enrollment transfer is performed in error, a transfer cancellation may be performed. This action results in reinstatement of the enrollment with the previous enrolling organization.

1.2.7.4. Enrollment Period Change

This event is used to update an enrollee's begin or end date. These modifications can only be performed by the enrolling organization responsible for managing the enrollment, and must be performed within the timeframes established in the business rules (see Chapter 3, Addendum D). DEERS changes the date range for a PCM selection based on the enrollment period changes. As previously stated, a change to an end date may only occur after a disenrollment. DEERS modifies the enrollee's policy based on the new date(s) if necessary.

If a person's eligibility in DEERS changes and affects an enrollment because the eligibility period is either greater or less than originally stated, DEERS updates the enrollment period and pushes the PCM and policy changes to the appropriate systems managing the enrollment. See the Unsolicited Notifications section for more information.

1.2.7.5.   Enrollment End Reason Change

Disenrollments can be done for various reasons, and are mostly done by enrolling organizations. If a disenrollment is performed by an enrolling organization using an incorrect end reason code, the end reason code can be updated. Enrolling organizations may not change an end reason indicating loss of eligibility if the end date of the enrollment coincides with the end date of eligibility for that enrollment.

1.2.7.6.   Enrollment/Disenrollment Cancellation

Enrollment and disenrollment cancellations can only be performed by the entity managing the affected enrollment. An enrollment cancellation completely removes the enrollment from DEERS, and it will not be shown on subsequent inquiries. A disenrollment cancellation is used to reinstate the prior enrollment. Both events must be done within the time period prescribed in the business rules (see Chapter 3, Addendum D).

1.2.8.   Enrollment Fees and Enrollment Fee Waivers

DEERS records and displays enrollment fee payment information and returns accumulated enrollment fee payment information by policy for the enrollment year in DOES.

DEERS supports several enrollment-fee-related transactions:

- Enrollment Fee Payment
- Update Individual Enrollment Fee Waiver Information
- Terminate Policy For Failure To Pay Fees

1.2.8.1.   Enrollment Fee Payment

Enrollment fees may be paid periodically (e.g., monthly, quarterly, or annually). The beneficiary specifies this payment option during enrollment and the MCSC or USFHP provider may enter the fee information in DOES as part of the enrollment transaction. To send DEERS fee information separate from the enrollment, MCSC's should use the batch enrollment fee payment process. If this information is entered into DOES, DEERS includes it on the notification to the MCSC or USFHP provider. MCSCs and USFHP providers also update DEERS with subsequent enrollment fee payments for a policy when the quarterly or monthly option is selected, or to update a fee paid-through date or fee payment exception reason. The MCSC shall send all fee payment updates to DEERS within one business day. The subscriber's DEERS ID, policy, and enrollment fee payment information are required when performing this transaction. DEERS keeps track of the accumulated enrollment fee payment information by policy for the enrollment year.

DEERS records both the enrollment fee payment date and the enrollment fee paid-through date. The enrollment fee paid-through date reflects the time period for which coverage is paid. The date represents neither when the enrollment fee payment information was received nor when it was sent to DEERS. The purpose of tracking the period an enrollment fee covers is to ensure portability. On an enrollment transfer, DEERS includes the fee information from the enrollee's policy on the notification to the new MCSC or USFHP provider.

DEERS does not prorate fees, determine the amount of the next enrollment fee payment, determine the date of the next enrollment fee payment, send enrollment fee payment due notifications, identify what entity is responsible for enrollment fee payments, or automatically apply enrollment fee payments to catastrophic cap accumulations. These actions are the responsibility of the enrolling organization. Additionally, the enrolling organization must be able to accommodate policies that are less than 12 months in length and prorate enrollment fees appropriately.

Under certain circumstances, enrollment fees may not be required because the catastrophic cap amount has been met or an enrollment fee payment is waived for an individual. If the catastrophic cap amount has been met for the family, no further enrollment fee payment should be collected for the remainder of that enrollment period. This non-payment fee information should be sent to DEERS by the enrolling organization indicating the catastrophic cap was met for this period. In the same way, an enrollment fee payment may be less than the amount expected for the coverage plan because there is an individual in the policy who is exempt from paying fees due to a waiver or the fee payment would exceed the catastrophic cap limit. The reason for a partial or non-payment of enrollment fee information would be sent to DEERS using the HCDP Enrollment Fee Payment Exception Reason Code. It is necessary for DEERS to have this information for portability.

See Chapter 3, Addendum C, HCDP Plan Coverage Details, for information on which coverage plans require fees.

1.2.8.2.   Split Enrollments And Enrollment Fee Payment

Split enrollments occur when all family members are covered under the same type of coverage but do not reside in the same contract region causing the enrollments to be administered under multiple contracts. In this situation, and until all enrollments are migrated to the new T-NEX regional contracts, a policy for the family will exist for each current MCS contract. As enrollments are migrated to the new T-NEX regional contracts DEERS will consolidate all split policies that are within the new T-NEX regional contract and communicate this information to the incoming T-NEX MCS contractor via an initial load file. The incoming T-NEX MCSC shall communicate to the beneficiaries whose policies have been consolidated and apply any fee payment overage to the next fee obligation. Any fee payment overage shall be applied first to the new fee obligation within the existing policy period. If there is additional overage, it shall then be applied to the new policy period when the policy is established on DEERS (i.e., 45 days prior to the expiration of the current policy). If an enrollment transfer occurs after the new T-NEX MCSC receives the initial load file, the same procedure is used except DEERS will notify the contractor of the policy changes and fees through a Policy Change Notification Transaction (see Chapter 3, Addendum D New Medical Business Rules). In addition, enrollment fees may be collected from several locations for policies in a split enrollment situation. DEERS accepts and stores enrollment fee payments from multiple MCSCs or USFHP providers. DEERS does not determine the entity or location responsible for collecting and reporting enrollment fee payments. The MCSCs and USFHP providers are responsible for ensuring that the total fees received collectively for a policy involving split enrollments do not exceed the applicable enrollment fee amount.

1.2.8.3.   Batch Fee Payments

In addition to sending enrollment fee payment information to DEERS through DOES, the MCSC may also send the information to DEERS in batch format. The batch fee payment updates include new payments, payment adjustments, and updates to enrollment fee payment exception reason codes, or paid-through dates. MCSCs and USFHP providers must be able to resubmit enrollment fee payments rejected by DEERS.

The following figure illustrates the process for sending batch fee payment updates to DEERS:

FIGURE 3-1.5-5   BATCH FEE PAYMENT PROCESS
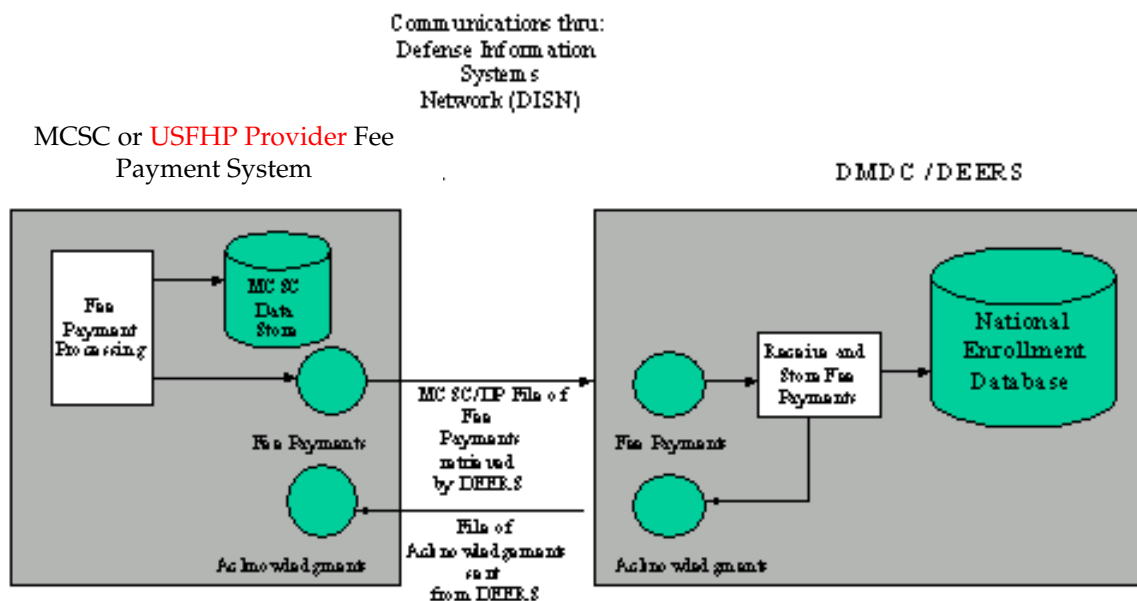
1.2.9.   Enrollment Attribute Updates

The DOES application supports the entry of additional enrollment-related information to support MCSC and USFHP provider processing that is external to DEERS. The following sections describe the data that may be entered or updated in DOES. Upon entry of update of this information, DEERS sends a notification to the MCSC or USFHP provider reflecting the update.

1.2.9.1.   Enrollment Fee Waiver Update For An Individual

Under certain circumstances (e.g., beneficiaries under age 65 with Medicare Parts A and B), enrollment fees may be fully or partially waived. Fee waivers should not be confused with non-payment of enrollment fees due to meeting catastrophic cap amounts. Enrollment fee waivers are associated at the individual beneficiary level and should be sent to DEERS by the MCSC or USFHP provider. For example, if three family members are waived from paying enrollment fees, an enrollment fee waiver must be applied to each person individually. The waiver information is a reason that indicates that there is a waiver

during an enrollment period. There are no dates associated with the enrollment fee waiver and waiver information can be updated at any time during the enrollment period. The fee payment waiver status for an individual is used to distinguish between enrollment fees that were waived versus ones that were not paid. If a family is disenrolled due to failure to pay enrollment fees, and there is an individual family member with an enrollment fee waiver, that individual cannot be disenrolled, because he or she is exempt from paying fees. The MCSC is responsible for setting and removing enrollment fee waivers as appropriate.

1.2.9.2.   Work ZIP Code

A work ZIP Code is supported for TRICARE Prime Remote plan determinations. TRICARE Prime Remote plan determinations are based on the sponsor's daily work location and residential ZIP Codes as well as the family member's residential ZIP code. Refer to Chapter 3, Addendum D, DEERS Medical Business Rules, for more information.

1.2.10.   Re-Enrollment

Many types of coverage plans require annual re-enrollment. The Fiscal Year will be used to track annual enrollment years for enrollment fee payments and CC&D accumulations for all new enrollments as well as renewals for transitioned or transferred policies. Annual re-enrollment, where required by plan, is handled simultaneously by the MCSC or USFHP provider and DEERS. DEERS will create a new enrollment year for the policies requiring re-enrollment on the 16th of the month prior to the month the policy expires. For example, if a policy on ends on September 30th, the re-enrollment will occur on August 16th. If the enrolled beneficiaries lose eligibility prior to the end of the next enrollment year, DEERS adjusts the policy to the latest end of eligibility date for the family and notifies the MCSC or USFHP provider of the new policy end date. See Split Enrollment and Enrollment Fee Payments (paragraph 1.2.8.2.) for more details on the migration of enrollment year to fiscal year basis.

1.3.   Address And Telephone Number Updates

DEERS receives address information from a number of source systems. The mailing address captured on DEERS is primarily used to mail the enrollment card and other correspondence. The residential address is used to determine enrollment jurisdiction in cases where a beneficiary has separate mailing and residential addresses. Jurisdiction is performed at the ZIP Code level. A beneficiary update is used to update addresses. Beneficiaries may provide up to three addresses (residential, mailing and temporary) which are entered into DEERS using DOES. The TRICARE enrollment form contains a mailing address and a residential address. Addresses are updated through the DOES application. DOES uses a commercial product to validate address information online.

DEERS has several types of telephone numbers for a person (e.g., home, work, and fax). These telephone numbers can be added and updated as necessary by the MHS and MCSC/USFHP provider. Phone numbers are updated through the DOES application.

DEERS also stores a home e-mail address for a person. This e-mail address can be added and updated as necessary by the MHS and MCSC or USFHP provider. The home e-mail address is updated through the DOES application.

DEERS allows MHS personnel to update beneficiary address and telephone number information for sponsors and family members in the DEERS database.

1.4.   Notifications

Notifications are sent to MCSCs and USFHP providers for various reasons, and reflect the most current policy information for a beneficiary. The MCSC or USFHP provider must accept and store the data contained in the notification as sent from DEERS. Notifications may be sent resulting from new enrollments for the MCSC or USFHP provider to manage, or updates to existing enrollments. If the MCSC does not have the information contained in the notification, the MCSC shall add it to their system. If the MCSC already has enrollment information for the beneficiary, the MCSC shall apply all information contained in the notification to their system. The MCSC shall use the DEERS ID to match the notification to the correct beneficiary in their system. There are also circumstances where a MCSC or USFHP provider may receive a notification that does not appear to be updating the information that the MCSC or USFHP provider already has for the enrollee. Such notifications shall not be treated as errors by the MCSC or USFHP provider system and must be applied. DEERS encrypts all notifications, and the MCSC or USFHP provider is responsible for decryption. The MCSC or USFHP provider is expected to acknowledge all notifications sent by DEERS. If DEERS does not receive an acknowledgement, the notification will continue to be sent until acknowledgement is received. The following information details examples of events that trigger DEERS to send notifications to a MCSC or USFHP provider.

1.4.1.   Notifications Resulting From Enrollment Actions

DEERS sends notifications to MCSCs and USFHP providers detailing any policy or PCM update performed in the DOES application. This includes address updates made for enrollees. Additionally, DOES supports a feature for the MCSC to request a notification to be sent without updating any address or enrollment information. The purpose of this request is to re-sync the MCSC or USFHP provider system with the latest DEERS policy data.

1.4.2.   Unsolicited Notifications

These types of notifications are unsolicited to the MCSC or USFHP provider and result from updates to a sponsor or family member's information made by an entity other than the enrolling MCSC or USFHP provider. Unsolicited notifications may result from various types of updates made in DEERS:

- Change to eligibility. As updates are made in DEERS that affect a beneficiary's entitlements to TRICARE benefits, DEERS modifies policy data based on those changes and sends notifications to the MCSC or USFHP provider and to CHCS, if appropriate. One example of this type of notification is notification of loss of eligibility, previously described in this document.

- Extended Eligibility. For example, in the case of a 21-year old child that shows proof of being a full-time student, eligibility is extended until the 23rd birthday.

- SSN, name, and date of birth changes. Updates to an enrolled sponsor or beneficiary's SSN, name, or date of birth are communicated via unsolicited notification to the MCSC or USFHP provider.

- Address change made by another entity. The notification also includes information as to which type of entity made the update. As noted earlier, DEERS validates the updated address using a Commercial-Off-The-Shelf (COTS) product online as address updates are made. Address changes performed by CHCS are also sent to the MCSC or USFHP provider.

- Data corrections made by DSO or the DOES Help Desk. If a MCSC requests the DSO to make a data correction for a current or future enrollment that the MCSC or USFHP provider cannot make themselves, notification detailing the update is sent to the MCSC or USFHP provider, and to CHCS, if appropriate.

1.4.3.   Patient ID Merge

Occasionally, incomplete or inaccurate person data is provided to DEERS, and a single person may be temporarily assigned two Patient Ids. When DEERS identifies this condition, DEERS makes this information available online for all MCSCs and USFHP providers. The MCSC is responsible for retrieving and applying this information on a weekly basis. The merge brings the data gathered under the two Ids under only one of the Ids and discards the other. Although DEERS retains both Ids for an indefinite period, from that point on only the one remaining ID shall be used by the MCSC or USFHP provider for that person and for subsequent interaction with DEERS and other MHS systems. If there are enrollments under both records being merged that overlap, the enrolling organizations are responsible for correcting the enrollments.

1.5.   Enrollment Cards And Letter Production

DEERS is responsible for producing the TRICARE universal beneficiary card for both CONUS and OCONUS. The cards are produced for beneficiaries enrolled in TRICARE Prime and TRICARE Remote. Enrollment cards are not produced for enrollments with USFHP providers.

New enrollment cards are automatically sent upon a new enrollment or an enrollment transfer to a new MCSC, unless the enrollment operator specifies in DOES not to send an enrollment card. Cards are also automatically generated upon a PCM change to a new TRICARE region that has different information-line phone numbers than the previous region or upon a change of a coverage plan that changes the type of card.

A MCSC may request a replacement enrollment card for an enrollee at any time. DEERS sends enrollment card request information in a notification to the MCSC indicating the last date an enrollment card was generated for the enrollee.

Along with the enrollment card, DEERS sends a letter to the beneficiary indicating their PCM selection as entered in DOES.

The MCSC may initiate a PCM change that does not require a new enrollment card. In these cases, DEERS sends a PCM change letter to the beneficiary. In the event PCM change

letters or enrollment cards are returned to the MCSC due to a bad address, the MCSC researches the address, corrects it on DEERS, and re-mails the correspondence to the beneficiary.

1.6.   Claims, Catastrophic Cap, And Deductible Data (CC&D)

DEERS is the system of record for eligibility and enrollment information. As such, in the process of claims adjudication, the MCSC shall query DEERS to determine eligibility and/or enrollment status for a given period of time. The MCSC shall use DEERS as the database of record for:

- Person Identification
- Eligibility
- Enrollment and PCM information
- Fiscal year to date totals for CC&D amounts
- Other Government Program (OGP)

Upon receipt of this data from DEERS, the MCSC shall not override this data with information from other sources.

Although DEERS is not the database of record for OHI, it is a centralized database of OHI information that is reliant on the MHS organizations to verify, update and add to at every opportunity. An MHS organization can verify, update or add OHI during eligibility and enrollment claims inquiries, or direct OHI related events identified in the Other Health Insurance section of this document. The OHI data received as part of the claims inquiry shall be used as part of the claims process. If the MCSC has evidence of additional or more current OHI information they shall process claims using the additional or more current information. After the claims process is complete, the MCSC shall send the updated or additional OHI information to DEERS using the system to system process or other mechanisms identified in the Other Health Insurance section of this document.

DEERS stores fiscal year CC&D data in a central repository. The purpose of the DEERS CC&D repository is to maintain and provide accurate CC&D amounts, making them universally accessible to DoD claims-processors.

1.6.1.   Data Events: Inquiries And Responses

This section identifies the main events, including the inquiries and responses between the MCSCs and DEERS, associated with CC&D transactions.

The main events to support processing this information include:

- Health Care Coverage Inquiry for Claims
- CC&D Totals Inquiry
- CC&D Amounts Update
- CC&D Transaction History Request

FIGURE 3-1.5-6   CLAIMS INQUIRY TO DEERS
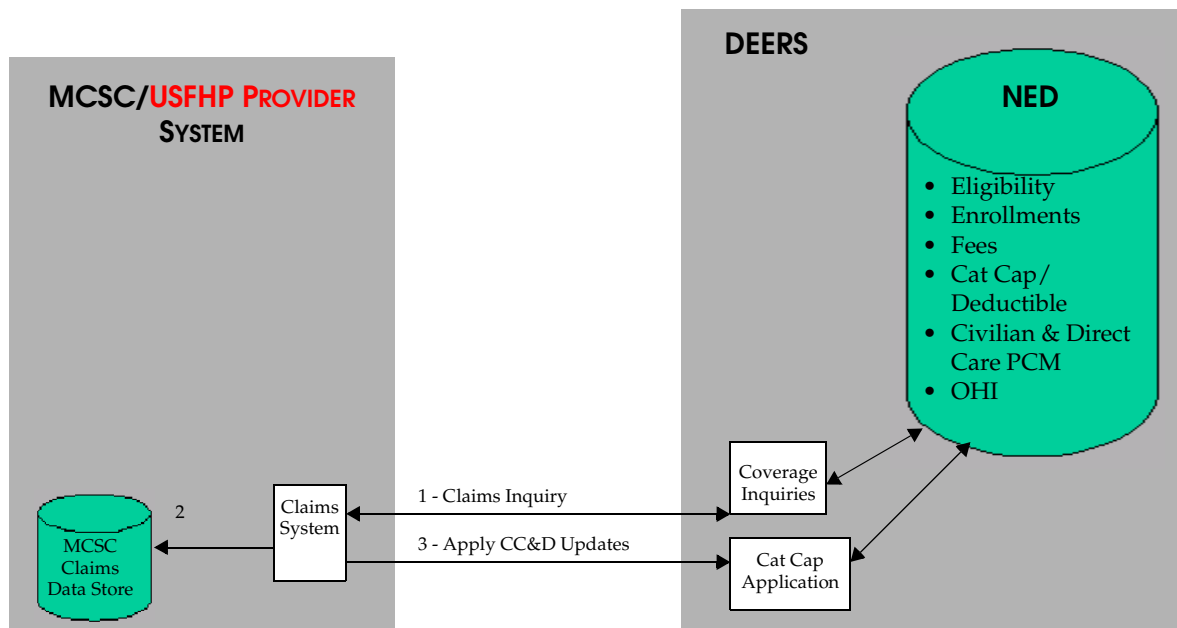
1.6.1.1.   Health Care Coverage Inquiry For Claims

The contractor shall install a prepayment eligibility verification system into its TRICARE operation that results in a query against DEERS for TRICARE claims and adjustments. The interface should be conducted early in the claims processing cycle to assure extensive development/claims review is not done on claims for ineligible beneficiaries.

The DEERS Health Care Coverage Inquiry for Claims supports business events associated with health care coverage and CC&D (CC&D) data for processing medical claims. This inquiry may also be used for general customer service requests or for referrals and authorizations.

The MCSC must use the eligibility, enrollment, OHI, Other Government Programs (e.g., Medicare), PCM, and CC&D information returned on the DEERS response to process the claim.

There are multiple options for inquiring about coverage information while including CC&D information. These different inquiry options allow the inquirer to receive coverage information and CC&D totals with or without locking the CC&D information for the family. A coverage inquiry and lock of the CC&D accumulations is necessary prior to updating this data on DEERS. Therefore, the Health Care Coverage Inquiry for Claims includes a locking option to specify whether or not DEERS should lock the CC&D amounts.

For audit and performance review purposes, the contractor is required to retain a copy of every transaction and response sent and received for claims adjudication procedures. This information is to be retained for the same period as required by the TRICARE Policy or TRICARE Operations Manual.

Unless notified by the contracting officer, the contractor may not bypass the query/response process for the prior day's claims if either DEERS or the contractor is down for twenty-four (24) hours or any other extended period of time. Instead, when this situation occurs, the contractor shall work directly with DEERS to develop a mutually agreeable schedule for processing the backlog. The contractor shall develop a method for ensuring the query/response process continues, even if an extended period of downtime occurs. This alternative method can be either a batch backup to the on-line system, weekend processing, off-hours processing, or any other method proposed by the contractor and accepted by DEERS and TMA.

1.6.1.1.1.   Exceptions To The DEERS Eligibility Query Process

Claims processing adjudication requires a query to DEERS except in cases where a claim contains only services that will be totally denied and no monies are to be applied to the deductible.

There are two exceptions to the requirement for sending a query for TRICARE adjustments. No query is needed for:

- Negative Adjustments
- Total Cancellations

1.6.1.1.2.   Information Required For A Health Care Coverage Inquiry For Claims

The information needed to perform this type of coverage inquiry includes:

Person identification information, including person or family transaction type

- Begin and end dates for the inquiry period
- CC&D lock option
- Option to request CC&D totals

1.6.1.1.3.   Person Identification

A beneficiary's information is accessed with the coverage inquiry using the identification information from the claim. DEERS performs the identification of the individual and returns the system identifiers (DEERS ID and Patient ID). The DEERS Ids shall be used for subsequent communications on this claim. Please reference the DEERS ID section for more information on obtaining the DEERS ID.

1.6.1.1.4.   Inquiry Options: Person Or Family

The inquirer must specify if the coverage inquiry is for a person or the entire family. The person inquiry option should be used when specific person identification is known. If person information is incomplete, the family inquiry mode can be used. In family inquiries, the Inquiry Person Type Code is required to indicate if the SSN, Foreign ID, or Temporary ID is for the sponsor or family member. In such inquiries, DEERS returns both sponsor and family member information. If there is more than one person or family match, the correct person must be selected, then the coverage inquiry re-sent. Refer to the Duplicate Person Identification section for more information.

1.6.1.1.5.   Inquiry Period

In addition to identifying the correct person or family, the inquirer must supply the inquiry period. The inquiry period may either be a single day or span multiple days. Historical dates are valid, as long as the requested dates are within three years. The inquirer queries DEERS for information about the coverage plans in effect during that inquiry period for the sponsor and/or family member. The reply may include one or more coverage plans in effect during the specified period.

1.6.1.1.6.   CC&D Lock Option

The inquirer must indicate whether or not to place a lock on the CC&D information. Use the lock option if you are performing the inquiry for claims processing and you intend to send updates to the DEERS CC&D.

DEERS maintains locks on CC&D data as needed for CC&D totals and updates. When the MCSC indicates that they would like to place a lock, the MCSC must provide a claim identifier, enrollment fee identifier, or adjustment identifier. DEERS refers to this as the CC&D Detail ID, and the CC&D Detail Type Code indicates the type of update being made. This identifier is used for locking and is checked against the identifier used for updating the CC&D amounts. DEERS determines the source of the lock, the lock date, and the lock time.

DEERS supports the following lock functionality:

- No Lock – No lock is in place.

- Lock – All MCSCs other than the MCSC organization that placed the lock is locked out. Only the MCSC organization that initiated the lock is able to access and update totals, and the detail identifier used for locking must match the detail identifier used for updating.

The claims lock period is 48 hours or until the lock is released, whichever comes first. If the MCSC needs more than 48 hours to adjudicate the claim, they may extend the lock by performing another coverage inquiry to lock a locked record. When this happens, a new lock date and time is set. Only the same locking organization that placed the lock may extend the lock, and only if the CC&D detail update identifier matches the identifier used to initially lock the record. DEERS does not support a separate "continue lock" feature.

NOTE: A lock is placed on the subscriber's family CC&D records. The family is made up of the subscriber and all associated family members.

If the inquirer elects to lock the CC&D totals with the coverage inquiry; there is not more than one person or family match; and the person has only one DEERS ID, then DEERS only returns person information. If there is a multi-person match, or the person has multiple DEERS Ids, DEERS does not perform the lock of the CC&D totals. The inquirer must then select the correct person and inquire again using the DEERS ID to get the coverage information and lock the totals. Refer to the Duplicate Person Identification section for more information.

1.6.1.1.7.   Option To Request CC&D Totals

The MCSC should use the option to request CC&D Totals if they are processing claims and intend to update CC&D. This option will return the CC&D Totals in the Claims Coverage response. The MCSC does not use this option when inquiring for purposes of general inquiry or referrals.

1.6.1.2.   Information Returned In The Health Care Coverage Inquiry For Claims

The different responses that DEERS could return for this inquiry include:

- Coverage with CC&D Totals: DEERS would return coverage and totals information. If the totals are presently locked, DEERS would also include lock information in the response to indicate they may not be accurate, even though a lock was not requested in the inquiry.

- Coverage with CC&D Totals and Lock Information: DEERS would return coverage information, applicable totals, and lock information, if the inquirer specified to include and lock totals in the coverage inquiry, only if the totals were not presently locked.

- Coverage with Lock Information Only -No CC&D Totals: DEERS would only return coverage and lock information if the inquirer specified to include and lock totals and the beneficiary's information was already locked. No totals would be returned in this case, because the totals were presently locked.

The DEERS ID is returned in response to a coverage inquiry. The MCSC should store the DEERS ID for use in subsequent update transactions for this claim. The DEERS ID ensures correct person identification and provides uniform beneficiary identification across the MHS. In addition, the Patient ID is returned in the coverage response. The MCSC is required to store the Patient ID. The Patient ID provides uniform person identification and patient identification across the MHS. The MCSC must put the Patient ID and DEERS ID on the TRICARE Encounter Data (TED) record.

1.6.1.2.1.   Data Returned In A Coverage Inquiry That Repeats For Every Coverage Plan

In response to a Health Care Coverage Inquiry for Claims, DEERS returns the specified coverage information in effect for the inquiry period. The following list shows the information DEERS returns for each coverage plan in effect during the inquiry period:

- Coverage plan information (assigned or enrolled)

- Coverage plan begin and end dates for inquiry period

- Sponsor branch of service and family member category and relationship to the sponsor during coverage period

1.6.1.2.2.   Data Returned In A Coverage Inquiry Independently From The Coverage Plan Information

The DEERS coverage response could include PCM, OHI and OGP information, and CC&D totals and lock information, independently from the health care coverage

information. If no PCM, OHI, and OGP information is returned, this means that DEERS does not have this information in effect for the requested inquiry dates.

- Sponsor Personnel Information: All current personnel segments will be returned, including dual eligible segments. The MCSC shall not use this information for claims processing. This information is intended to be used for the TED only.

- Primary care manager information: PCM information is returned for some enrolled coverage plans. No PCM information is present for the DoD-assigned coverage plans and some enrolled coverage plans. PCM information provided includes DMIS, the PCM Network Provider Type Code, and individual PCM information if available in DEERS.

- Other Health Insurance: Limited OHI information is returned.

- Other Government Programs: Complete OGP information is provided in the response. OGPs include CHAMPVA and Medicare.

- CC&D totals: Both family and individual CC&D accumulations are provided in the coverage response. If a lock is requested and the information is already locked, DEERS does not return the CC&D accumulations.

The DEERS response shows year-to-date CC&D totals for each HCDP (e.g., TRICARE Standard) as necessary. Based on the inquiry dates requested, DEERS determines the appropriate fiscal year and returns the totals for the respective periods within each HCDP. Both individual and family totals are displayed, showing CC&D balances separately. If there are no CC&D totals accumulated for the inquiry period requested, DEERS shows a zero value.

If the inquiry period spans fiscal years, the CC&D totals would repeat multiple times. For example, if the inquiry dates are September 1, 2000 through October 25, 2001, there would be two sets of fiscal year totals, one for FY 2000 and one for FY 2001.

- CC&D lock option: Lock information is always returned with the coverage and CC&D accumulation information when a lock is requested or exists.

If an MCSC inquires for CC&D totals and does not place a lock on the totals, DEERS would return any totals accumulated for the inquiry period and lock information if the totals were presently locked. If an MCSC inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that MCSC's lock information, including their lock organization, lock date, and lock time. If an MCSC inquires and locks CC&D totals for a beneficiary whose totals are already locked, only the lock organization, lock date, and lock time are returned. No totals are returned in this situation.

1.6.1.2.3.   Health Care Coverage Copayment Factor For Coverage Inquiries

The copayment for an insured is determined using information provided by DEERS and may also include treatment information from a claim. The different factors are

determined by legislation, which considers factors such as pay grade and personnel category, such as retired sponsor or active duty.

The Health Care Coverage Copayment Factor Code is determined by DEERS and is returned on a claims inquiry. The MCSC shall use this factor code to determine the actual copayment for the claim.

Examples of copayment factors are:

- Pay Grade Corporal/Sergeant or Petty Officer Third Class and below rate

- Pay Grade Sergeant/Staff Sergeant or Petty Officer Second Class and above rate

- Retiree and Surviving family members of deceased activity duty sponsors rate

- Foreign Military rate

NOTE: More rate codes can be added, as required by the DoD.

Although the rates are based on the population to which they pertain, such as retired sponsor, these rates also apply to a sponsor's family members.

1.6.1.2.4.   Special Entitlements

Congressional legislation may effect deductibles and rates. The Special Entitlement Code, and dates if applicable, provide information to support this legislation. Examples are:

- Special entitlement for participation in Operation Joint Endeavor – this code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the Special entitlement section of the data returned.

- Special entitlement for participation in Operation Noble Eagle – this code, when returned from a claims inquiry to DEERS, will waive or reduce the annual deductible charges of the beneficiary for the period indicated by the effective and expiration dates of the Special entitlement section of the data returned. In addition, non-participating physicians will be paid up to 115% of the CMAC or billing charges whichever is less.

Effective dates will also be included in the response from DEERS. A person may have multiple special entitlements. Refer to TRICARE Operations Manual and TRICARE Policy Manual.

1.6.1.3.   Multiple Responses To A Single Health Care Coverage Inquiry for Claims

DEERS may need to send multiple responses to a single Health Care Coverage Inquiry for Claims, and these responses are returned in a single transaction. This situation could occur if a person has multiple DEERS Ids within the inquiry period. It is necessary for

DEERS to capture family member entitlements and benefit coverage corresponding to each instance of the person's DEERS ID. For example, in a joint service marriage, a child may be covered by the mother from January through May (DEERS ID #1) and covered by the father from June through December (DEERS ID #2).

Figure 3-1.5-7   Health Care Coverage Inquiry For Claims: Responses And Actions

CONDITION	MESSAGE RETURNED	MCSC ACTION
1. Sponsor not found	Sponsor not in database	Deny claim and direct beneficiary to a military ID card facility to have information updated in DEERS.
2. Person not found	Person not found	Deny claim and direct beneficiary to a military ID card facility to have information updated in DEERS.
3. Multiple sponsors matched	Partial match	Select correct sponsor, re-query DEERS.
4. Sponsor found, family member not found	Partial match	Select correct family member, re-query DEERS.
5. Sponsor found, multiple family members matched	Partial match	Select correct family member, re-query DEERS.
6. Sponsor found, family member found	Health care coverage	Adjudicate claim based on response.

If the contractor is unable to select a patient from the family listing provided by DEERS, the contractor shall check the patient's date of birth. If the date of birth is within 365 days of the date of the query (i.e., a newborn less than l year old), the contractor shall release the claim for normal processing.

If the date of birth is over 365 days from the date of query, the contractor shall check the duty station or residence of the sponsor. If the sponsor resides overseas and/or an APO/FPO address is indicated for the sponsor, the claim shall be released for normal processing.

Contractors shall deny a claim (either totally or partially) if the services were received partially or entirely outside any period of eligibility.

CHAMPVA claims shall be forwarded to Health Administration Center, CHAMPVA Program, PO Box 65024, Denver CO 80206-5024.

A list of key DMDC Support Office (DSO) personnel and the Joint Uniformed Services Personnel and Medical Advisory Committee Members is provided at the TMA web site at http://www.tricare.osd.mil. These individuals are designated by the TMA to assist DoD beneficiaries on issues regarding claims payments. In extreme cases the DSO may direct the claims processor to override the DEERS information; however, in most cases the DSO is

able to correct the database to allow the claim to be reprocessed appropriately. The procedure the contractor shall use to request data corrections is in Chapter 3, Section 1.6.

Any overrides issued by the DSO will be in writing detailing the information needed to process the claim. Overrides can not be processed verbally, and overrides are not allowed in cases where correction of the data is the appropriate action. Only in cases of aged data that can not be corrected will DSO authorize an override. The contractor will provide designated points of contact (POC) for the DSO personnel and the JUSPAC/JUSMAC members identified on the TMA web site.

1.6.1.4.   CC&D Totals Inquiry

The CC&D Totals Inquiry is used to obtain CC&D balances for the fiscal year(s) that correspond to the requested inquiry period. The MCSC must inquire and lock CC&D totals before updating DEERS CC&D amounts with enrollment fee payment information.

1.6.1.4.1.   Information Required To Inquire For Totals

The following information details the data required to inquire for CC&D totals.

1.6.1.4.1.1.   Person Information

The MCSC must have the DEERS ID, returned by DEERS on the policy notification, for this inquiry. Either the sponsor's or family member's DEERS ID is used for the totals inquiry. Even though only one person's DEERS ID is used, both individual and family totals will be returned in the response.

1.6.1.4.1.2.   CC&D Totals Inquiry Period

The inquiry period used for the CC&D Totals Inquiry may be a single date or a date range, not more than three years in the past. Future dates are not valid.

1.6.1.4.1.3.   Lock Indicator

The MCSC chooses whether to lock CC&D totals. However, if the MCSC intends to update the CC&D amounts, the MCSC must lock the CC&D totals. See locking description in the Health Care Coverage Inquiry section.

1.6.1.4.1.4.   Response To CC&D Totals Inquiry

The following information details the information returned from a CC&D totals and inquiry.

1.6.1.4.1.5.   CC&D Totals

DEERS sends a response showing year-to-date CC&D totals for each HCDP (e.g., TRICARE Standard) as necessary. Based on the inquiry dates requested, DEERS will determine the appropriate fiscal year and return the totals within each HCDP. Both individual and family totals are displayed, showing CC&D balances separately. If there are

no CC&D totals accumulated for the inquiry period requested, DEERS will show a zero value.

If the inquiry period spans fiscal or enrollment years, the CC&D totals would repeat multiple times. For example, if the inquiry dates are September 1, 1998 through October 25, 1998, there would be two sets of fiscal year totals, one for FY 1998 and one for FY 1999

1.6.1.4.1.6. Lock Information

If an MCSC or USFHP provider inquires for CC&D totals and does not place a lock on the totals, DEERS would return any totals accumulated for the inquiry period and lock information if the totals were presently locked. If an MCSC inquires for totals with a lock and the totals were not presently locked, DEERS would return the accumulated totals and that MCSC's lock information, including their lock organization, lock date, and lock time. If an MCSC inquires and locks CC&D totals for a beneficiary whose totals are already locked, only the lock organization, lock date, and lock time will be returned. No totals will be returned in this situation.

The following diagram depicts a CC&D Totals Inquiry.

FIGURE 3-1.5-8   CATASTROPHIC CAP AND DEDUCTIBLE TOTALS INQUIRY
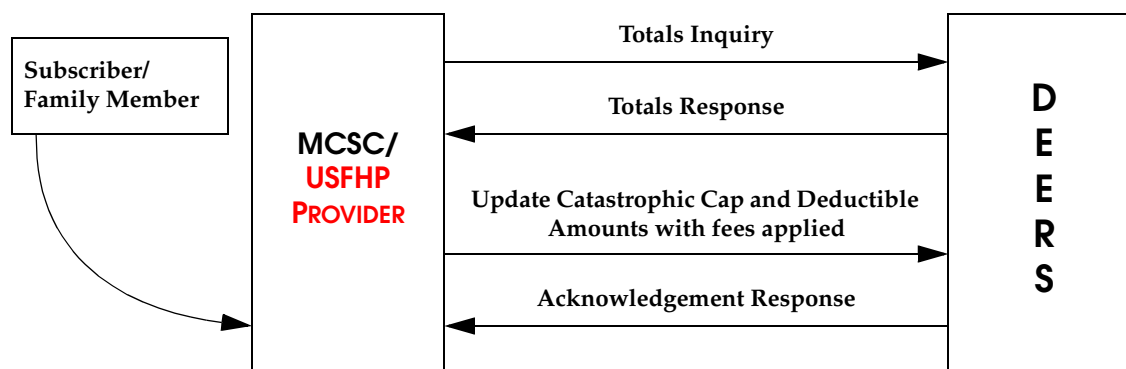
1.6.1.5. Updating CC&D Amounts

After a coverage or totals inquiry is performed and CC&D totals are locked, an MCSC may update DEERS CC&D amounts. This update transaction requires the DEERS ID, which may be obtained from a coverage or CC&D totals inquiry. Only the same organization that placed the lock may update the locked record and remove the lock. DEERS validates that the updating organization is the same as the organization that placed the lock. If there is a discrepancy, DEERS does not allow the update and sends a response that the update was not successful. If there are more claims outstanding for the same family, the MCSC may choose not to remove the lock. In this case, the record would remain locked until the 48-hour time period expires, or the lock is removed, whichever comes first.

CC&D amounts can be updated online for the previous three years. Each transaction should only include updates for one claim. CC&D amounts for multiple claims should be sent in separate transactions. In the split claim situation, multiple transactions must be sent for the same claim. For example, if a claim spans fiscal years and is split, updates for FY 2000 and FY 2001 must be sent in two transactions using the claim extension identifier (explained below) to distinguish the two updates from one another.

Do not send CC&D updates for programs for which they do not apply (e.g., PFPWD). See the TRICARE Policy Manual.

CC&D updates should be posted to DEERS even if the limit has been met.

1.6.1.5.1. Information Required To Update CC&D Amounts

The MCSC must provide the following information to update the CC&D amounts:

- DEERS ID: This identifies the beneficiary for whom the update is applied.

- Catastrophic cap, deductible, and/or point of service dollar amount

The MCSC sends DEERS the CC&D amount for the beneficiary. DEERS knows to which family the beneficiary belongs and rolls up the totals for the correct family using the DEERS ID.

- Identifier for the claim, enrollment fee, or adjustment

NOTE: If there is a discrepancy between the identifier used for locking and the identifier used for updating, DEERS does not allow the update.

- Claim extension identifier

When a claim spans fiscal years, the claim extension is used to identify a split claim. These claims should have the same claim identifier with a different claim extension identifier. Splitting the claim is the responsibility of the claims processor, who splits the claim, adds the claim extension, and sends this information to DEERS.

- Lock information (remove or do not remove lock).

- Dates provided for the catastrophic cap and/or deductible update.

The dates may include the date(s) of service for the claim (both begin and end date) or the fiscal year, as appropriate. These dates are necessary for accumulating the CC&D totals for the correct time period and HCDP.

- For fiscal year updates, the MCSC must send DEERS the fiscal year for which the CC&D applies.

- For updates associated with a claim, the period of service for the claim should be sent to DEERS, so that the information can be referenced with CC&D details.

1.6.1.5.2.   Types Of CC&D Updates

DEERS supports CC&D update functionality including adding, adjusting, and canceling amounts. Adds, adjustments, and cancellations may be made for the previous three years.

- Adds

The MCSC utilizes the CC&D update to add new CC&D amounts to the DEERS CC&D repository.

- Adjustments

The MCSC utilizes the CC&D update to adjust posted CC&D amounts. The same claim identifier as the original claim must be provided for the adjustment. A negative or positive amount should be entered, in order to correct the net amount. In order to adjust a claim, an MCSC must provide the same information for updating a claim as outlined in the previous section. For example, an MCSC updates a claim with a $50 catastrophic cap amount, then two weeks later discovers that the claim was incorrectly adjudicated and the catastrophic cap amount should have been $35. The MCSC would then update the beneficiary's catastrophic cap for the same claim number with an amount of -$15. The DEERS catastrophic cap balance would then show $35 for that claim.

- Canceling a catastrophic cap or deductible amount

The MCSC utilizes this update transaction to cancel (zero out a posted amount) a previously submitted catastrophic cap or deductible amount.

Claim cancellations are handled similarly to adjustments. For example, an MCSC updates a claim with a $120 deductible amount, then one week later discovers that this was incorrect, and there should not have been any adjudicated deductible amount. The MCSC would then update the insured's deductible with an amount of -$120. This would zero out the previous amount applied for that claim.

- The 48-hour rule

DEERS enforces a 48-hour lockout rule. If an MCSC places a lock on a record and fails to update that record within the specified 48-hour time period, the MCSC will be unable to update CC&D amounts, because the lock will have expired.

- Removing a lock

If an MCSC places a lock, then realizes the lock is unnecessary, the preferred way to remove that lock is to perform a CC&D update specifying to remove the lock. In this case, the MCSC would send no catastrophic cap or deductible amounts, only indicate the removal of the lock.

1.6.1.6.   Response To Updating CC&D Amounts

DEERS sends an acknowledgement message after a successful CC&D update. The following figure details the flow of a CC&D Amounts Update.

FIGURE 3-1.5-9   COVERAGE INQUIRY AND CC&D UPDATE PROCESS
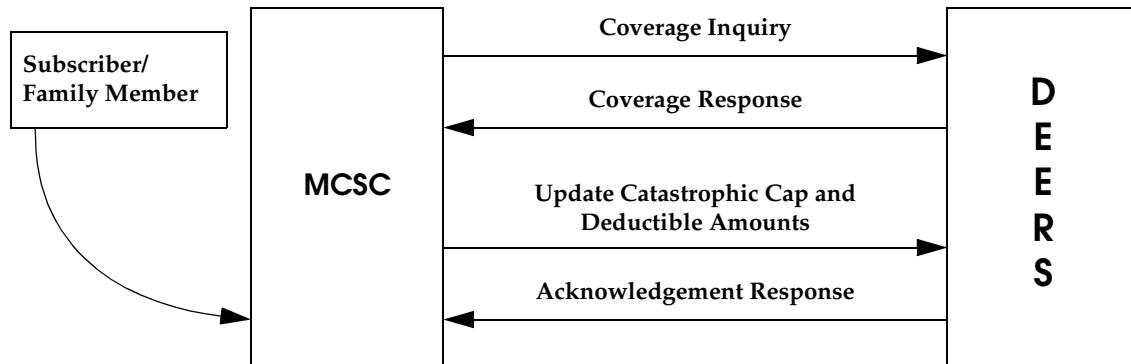
1.6.2.   CC&D Transaction History Request

CC&D transaction history information is useful for customer service requests, for auditing purposes, or for researching any problems associated with CC&D updates in relation to a particular claim.DEERS maintains a record of each update transaction applied toward CC&D information. This detailed transaction information is available through the CC&D transaction history request. The following transaction history request types are available:

- Specific beneficiary

- Fiscal year or inquiry period (begin and end month/year) for a specific beneficiary

- Specific detail identifier (claim number, enrollment fee, or adjustment)

1.6.2.1.   Information Required To Request A CC&D Transaction History

The required information for a transaction history request includes:

- Person identification information, including person or family transaction type

- Fiscal year or inquiry period begin and end dates

- Detail identifier (claim, enrollment fee, or adjustment), optional if interested in a specific update

1.6.2.1.1.   Person Identification Information

A beneficiary's information is accessed in the transaction history request using the DEERS ID.

1.6.2.1.2.   Person of Family Transaction Type

The inquirer must specify if the transaction history inquiry is for a person or the entire family. If an individual inquiry is sent, DEERS returns the beneficiary's individual details, individual accumulation, and family level CC&D accumulation. If a family inquiry is

sent, DEERS returns both sponsor and all associated family members' CC&D details and accumulations.

1.6.2.1.3.   Inquiry Period

The inquiry period may be either a fiscal year or a date range. Historical dates are valid, as long as the requested dates are within three years.

1.6.2.1.4.   Detail Identifier

The inquirer may query for CC&D transaction history information for a specific update using the detail identifier. The detail identifier corresponds to the claim number, enrollment fee identifier, or adjustment identifier used for posting the CC&D amounts. When the inquirer specifies a detail identifier for the inquiry, DEERS returns only CC&D updates that match that detail identifier.

1.6.2.2.   Information Returned In Response To A CC&D Transaction History Request

DEERS returns each individual CC&D detail that was applied during the inquiry period for the specified person or family. Fiscal year amounts are returned as appropriate. Amounts returned in the response may include both positive and negative amounts.

For example, if the inquiry period were Fiscal Year 2001, all CC&D amounts that were applied to the FY 2001 are returned in the transaction history response regardless of the date in which the update was actually sent to DEERS. DEERS does not use the transaction date to determine what detail to return in the response. DEERS uses the period to which the update actually applies.

If there is a lock currently placed on the CC&D totals, the locking organization, lock date, and lock time are also returned. In this way, the inquirer knows that there are claims in process for that family. DEERS also returns the detail identifying information used for each CC&D posted update including the system that performed the update, the transaction date and time for each record. DEERS does not return accumulated totals in the response.

1.6.2.3.   CC&D Data Transfer

TRICARE Standard CC&D data has been maintained in the Central Deductible and Catastrophic Cap File (CDCF) since FY 1995 for claims with a date of service on or after October 1, 1994. This data will be migrated from the CDCF to the DEERS CC&D repository via initial load.

TRICARE Prime Point of Service deductible data has been maintained separately by MCSC's. Because the TRICARE Prime Point of Service deductible data has not been stored centrally, the method by which this data will be transferred to the MCSC through contract transition.

1.6.2.4. **CC&D Data Storage**

DEERS stores CC&D data both by beneficiary and by HCDP. For TRICARE Standard and Extra, DEERS tabulates and stores CC&D balances by fiscal year, which is October 1 through September 30. DEERS treats Standard and Extra as one type of catastrophic cap.

For TRICARE Prime Point of Service, DEERS tabulates and stores the deductible balance by fiscal year.

DEERS stores and archives CC&D data. The most recent three years of CC&D data is maintained online after contract transition.

1.7. **Other Health Insurance**

Other Health Insurance (OHI) identifies non-DoD health insurance held by a beneficiary. The requirements for OHI are validated by the Uniform Business Office (UBO) and OASD (HA)/TMA--Resource Management (RM) (Management Control and Financial Studies (MC&FS)). OHI information includes:

- OHI policy and carrier

- Policyholder

- Type of coverage provided by the additional insurance policy

- Employer information offering coverage, if applicable

- Effective period of the policy

OHI transactions allow adding, updating, canceling, or viewing all OHI policy information, as opposed to the limited OHI policy information returned with eligibility or coverage inquiries. OHI policy updates can accompany enrollments or be performed alone.

OHI information can be added to DEERS or updated on DEERS through multiple mechanisms. At the time of enrollment the MCSC will determine the existence of OHI. The MCSC can add or update OHI through the DOES application used by the MCSC to enter enrollments into DEERS. Other MHS systems can add or update the OHI through the Web application provided by DEERS. In addition, DEERS will accept OHI updates from the claims processor through a system to system interface. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information.

The minimum information necessary to add OHI to a person record is the Health Insurance Carrier Name and OHI Policy Identifier. These fields are the minimum-required data entered at the time of enrollment or during any beneficiary contact when the beneficiary indicates he or she has OHI.

When an MHS organization is enrolling a person into a coverage plan, or updating person or patient data without the Health Insurance Carrier Name, there is a placeholder entry on the SIT that can be used to complete the process. The placeholder entry on the SIT

has a value of "Unknown" and can be used to indicate that an OHI policy exists for a beneficiary. This health insurance carrier of "Unknown" has an assigned Health Insurance Carrier Identifier (ID). For "Unknown" OHI policies the default coverage indicator is "medical"; however, any coverage indicator can be assigned to it. Monthly, DEERS provides the Uniform Business Office (UBO) and the entity that provided the policy a report of the persons with an "Unknown" OHI policy. The report details the persons' information and the systems that entered the "Unknown" policy. The enrolling entity or updating system is responsible for obtaining the complete OHI information.

DEERS requires the MCSC to perform a coverage inquiry or an OHI Inquiry before attempting to add or update an OHI policy. The MHS organizations are reliant on the individual beneficiary to provide accurate OHI information and DEERS is reliant on the MHS organizations for the accurate assignment of policy information to the individual record. In addition, DEERS is responsible for maintaining the OHI information on file; however, DEERS is reliant on the input source for the accurate assignment of a policy to a person. To understand this better, a patient would not be added or updated without first requesting the information from DEERS. Performing a coverage inquiry or an OHI Inquiry on a person before adding or attempting to update an OHI policy helps ensure that the proper policy is updated based on the most current information for the person.

DEERS does not track coordination of benefits priority because this information can change frequently and may not be accurate. Examples of the type of OHI coverages available are:

- Medical coverage
- Dental coverage
- Inpatient coverage
- Outpatient coverage
- Long-term care coverage
- Pharmacy coverage
- Mental health coverage
- Vision coverage
- Partial hospitalization coverage
- Skilled nursing care coverage

The default coverage is Medical Coverage unless the primary coverage is one of the coverages listed above. DEERS reports which coverage indicators are included within the OHI policy. In addition, each OHI policy carries a code indicating whether the policy is active, inactive, or deactivated. The deactivation of an OHI policy only occurs when the MHS SIT Validation Office (SVO) at TMA deactivates the health insurance carrier. Refer to the SIT section for more information. DEERS retains an OHI policy for three years after it becomes inactive, is deactivated, or expires.

1.7.1.   OHI Policy Inquiry

1.7.1.1.   Person Identification For OHI Policy Inquiry

OHI information is requested using the Patient ID, which is person-level identification. Person identification is used for the sponsor or family member. If the Patient ID is unknown, a coverage inquiry to DEERS can be done to obtain it.

1.7.1.2.   OHI Person Inquiry

The OHI data is by person and the OHI inquiry is only for individual person requests. DEERS allows multiple OHI policies for each person. DEERS does not support an inquiry that shows all insureds in a particular policy.

1.7.1.3.   OHI Information

There are multiple ways the requester can specify the OHI information for the inquiry. The requester can specify a time period (begin and end date) or through combinations of the time period, the Health Insurance Carrier ID, the Health Insurance Carrier Name, the OHI Policy ID and the specific OHI Coverage Indicator Code.

The Health Insurance Carrier ID represents the ID assigned to insurance carriers in the SIT provided by the DoD to DEERS. A requester can seek information on a specific coverage for a beneficiary by using the OHI Coverage Indicator Code in the OHI inquiry sent to DEERS, or for a specific insurance carrier by using the Health Insurance Carrier Name. If a requestor is unsure about a specific OHI Policy, a time period should be specified for the inquiry to return the OHI Policy information in effect.

1.7.1.4.   Information Returned In The OHI Inquiry Response

The DEERS response returns all OHI policies in effect during the specified time period for the beneficiary. OHI policies that are inactive or deactivated are returned if the OHI policies were in effect for any portion of the OHI inquiry period. If a specific coverage type is selected in the inquiry, only policies having that coverage are included in the DEERS response.

If DEERS cannot find the OHI policies for the specific coverage indicator, DEERS does not return any OHI policies for the requested OHI inquiry period. When the Patient ID is included in the OHI inquiry, the Patient ID is returned in the response.

1.7.2.   OHI Policy Add

DEERS allows the MHS and MCSC systems to add an OHI policy for a person when documented information is presented to the MHS clinical personnel or to the MCSC. A coverage inquiry or an OHI Policy Inquiry should be done prior to adding an OHI policy. This ensures that updates are performed with the most current information. Following the coverage inquiry or the OHI Policy Inquiry, the OHI data can be added as necessary. OHI data can be added during an enrollment via the DOES application. OHI can be added any time after enrollment though the Web application provided by DEERS, or through the system

to system interface with the claims processors. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information.

The fields required to add an OHI policy for a person are:

- Patient ID
- Health Insurance Carrier Name
- OHI Policy ID

When the MHS organization enters the Health Insurance Carrier Name DEERS will check it against the SIT for validation of the Health Insurance Carrier information. If the Health Insurance Carrier Name is not on the SIT, the MHS organization may enter the additional fields that will create a temporary add to the SIT, or just add the Health Insurance Carrier Name to the person as an indication that OHI exists. More information on the SIT is contained in paragraph 1.8.

The additional fields to add a complete OHI record for a person are:

- OHI Effective Calendar Date
- OHI Expiration Calendar Date
- Health Insurance Carrier ID
- OHI Policyholder Surname
- OHI Policyholder Forename
- OHI Policyholder ID
- OHI Policyholder Person Association Reason Code
- OHI Coverage Indicators for the policy

A person can have multiple OHI coverage indicators for one policy. For example, to add an OHI policy that covers medical and vision, two OHI coverage indicators, one for medical coverage and one for vision coverage would be sent to DEERS.

The Health Insurance Carrier ID, Other Health Insurance Policy ID, and OHI Effective Date cannot be updated once an OHI policy has been added to DEERS. These attributes, along with the person identification, uniquely identify an OHI Policy to a person.

The Health Insurance Carrier ID is associated with a verified insurer listed in the Standard Insurance Table (SIT). If there is no SIT entry for this health insurance carrier, a SIT transaction is performed and DEERS provides a temporary Health Insurance Carrier ID to be used in the interim for the Health Insurance Carrier ID. Refer to the SIT section of this document for additional information.

All messages sent to DEERS receive an acceptance or rejection acknowledgement.

1.7.3.   OHI Policy Update

DEERS allows the MHS systems to update existing OHI policy information for a person when documented information is presented. An OHI Policy Inquiry should be done prior to updating an OHI policy. This ensures that updates are performed with the most current information. Following the OHI Policy Inquiry, the OHI data can be updated as

necessary. OHI data can be updated during an enrollment via the DOES application. OHI can be updated any time after enrollment though the Web application provided by DEERS, or through the system to system interface with the claims processors. The presence of an OHI Policy discovered during routine claims processing shall be updated on DEERS within two business days of receipt of the required information. The minimum information needed to add an OHI to a person record is:

- Patient ID
- Health Insurance Carrier Name
- OHI Policy ID

1.7.4.   OHI Policy Cancellation

Cancellation of an OHI policy is done to disassociate an OHI policy from a person. **The OHI Policy Cancellation is not used to terminate an existing policy**. If the OHI policy exists for the person but some of the data is incorrect, it should be updated accordingly. An OHI policy cancellation completely removes the policy. DEERS verifies that the cancellation is performed by the entity that added or last updated the OHI policy.

When canceling an OHI policy, an OHI Policy Inquiry should be done to verify the information necessary to perform a cancel. Canceling an OHI policy requires the following data elements:

- Patient ID
- Health Insurance Carrier ID
- OHI Policy ID
- OHI Effective Calendar Date
- OHI Expiration Calendar Date

1.8.   Standard Insurance Table

The Standardized Insurance Table (SIT) program supports the MHS billing and collection process. The requirements for the SIT are validated by the Uniform Business Office (UBO) and OASD (HA)/TMA--RM (MC&FS). DEERS is the central repository of the SIT information for the use by the MHS organizations. The MHS SIT Validation Office (SVO) at TMA maintains the SIT in DEERS. The MHS personnel use the SIT to obtain other payer information in a standardized format. The SIT provides a uniform billing contact for reimbursement of medical care costs covered through policies held by the DoD person population.

The Health Insurance Carrier ID is the key used for associating a person's OHI policy with an insurance company on the SIT. During the initial deployment of the SIT on DEERS, the Health Insurance Carrier ID will consist of the first three letters of the insurance company name, the two-letter standard state abbreviation, and a two-character identifier assigned by the MHS SVO. Once a standard national health plan identifier is adopted by the Secretary, Health and Human Services (HHS), DEERS and trading partners will migrate to the identifier.

All systems identified as trading partners are notified when the initial SIT is available on DEERS for download. Entities or systems identified to DEERS as authorized

holders of a local copy of the SIT are notified when updates are made to the SIT on DEERS. These updates may result from a user request that is validated by the MHS SVO, or may be additions or updates directly from the MHS SVO.

Field users can do six actions with the SIT:

- An inquiry action to verify the information in the table for assignment of an OHI policy or to verify billing information

- An add action to report a new SIT entry for validation by the MHS SVO

- An update action to report an updated SIT entry for validation by the MHS SVO

- The cancellation of an update sent to the SIT for verification by the MHS SVO

- A query against a specific Health Insurance Carrier by Health Insurance Carrier Name or Health Insurance Carrier ID to identify the number of policies on DEERS for that carrier

- A query against a specific Health Insurance Carrier by Health Insurance Carrier Name or Health Insurance Carrier ID to identify the persons on DEERS who have policies with that carrier

1.8.1.   SIT Inquiry

The inquiry is done by submitting the Health Insurance Carrier Name or the Health Insurance Carrier ID if known. Additional information that may be submitted as part of a SIT Inquiry is the Health Insurance Carrier Type Code, if known, the Health Insurance Carrier Mailing Address US Postal Region State Code, and the Health Insurance Carrier Mailing Address Country Code. Regardless of the type of inquiry, DEERS returns all matching carrier information resident on the SIT. If there are multiple matches, based on incomplete carrier name, state, and country, DEERS returns a list of those carriers most closely fitting the inquiry.

1.8.2.   SIT Add

When the MHS personnel add a complete OHI record to a person or patient they will need the Health Insurance Carrier ID that matches an entry in the SIT, or a temporary Health Insurance Carrier ID provided by DEERS when the Health Insurance Carrier ID has not been verified by the MHS SVO. The Health Insurance Carrier ID represents the identifier assigned to insurance carriers in the SIT provided by the MHS SVO to DEERS. The Health Insurance Carrier ID Type Code identifies the ID as permanent or temporary.

Addition of an OHI policy to a person or patient does not automatically generate a request for an add to the SIT. If the MHS organization is only adding the Health Insurance Carrier Name and OHI Policy ID the entry will not generate a request to add to the SIT. However, when the MHS organization adds the full OHI record as part of an enrollment using DOES the SIT add process is handled as part of the enrollment process. The following data is necessary to generate a request to add an entry to the SIT:

- Health Insurance Carrier Name

- Health Insurance Carrier Mailing Address

• Health Insurance Carrier Telephone Number

The required SIT fields do not represent the OHI fields necessary to add a complete OHI record to a person. In addition, the identified fields do not represent the only data fields collected for SIT. The Business Rules identify the specific data fields that may be included as part of a SIT Add, Update or Cancel event.

The user will not have to stop the enrollment process to perform a request to add a Carrier to the SIT. A SIT add request posts the carrier information to the SIT pending validation by the MHS SVO. A description of the validation process is in a later section.

When an OHI carrier is not on the SIT, the user may send a request to add it to the SIT on DEERS. DEERS responds with a Health Insurance Carrier ID and a Health Insurance Carrier ID Type Code designation of "temporary." The temporary Health Insurance Carrier ID tracks the SIT update. When the MHS SVO validates the SIT, the agency assigns the permanent Health Insurance Carrier ID. DEERS sends the permanent Health Insurance Carrier ID with the other appropriate health insurance carrier information to all local holders of the SIT. In addition, DEERS updates the DEERS temporary carrier identifiers with the permanent Health Insurance Carrier ID on the affected OHI policies in DEERS.

1.8.3.   SIT Update

For updates to an existing SIT record, the existing Health Insurance Carrier ID is sent with the update. Without the Health Insurance Carrier ID, DEERS is not able to report a validation or a rejection of the SIT update. Returning all the insurer information in the update assists in the rapid validation of the SIT by the MHS SVO. For all SIT updates, DEERS retains the system identifier of the site performing the update. The MHS SVO uses the system identifier to report a rejection of the SIT update to the submitting site only.

DEERS does not allow an update to a health insurance carrier with a temporary Health Insurance Carrier ID, until validated or rejected by the MHS SVO. However, DEERS does allow the submitting site to cancel the update request prior to validation by the MHS SVO. See the SIT Add/Update Cancellation section for more information.

1.8.4.   SIT Add/Update Cancellation

The MHS personnel may need to cancel a previously submitted update to the SIT. A cancel can only be done by the system that submitted the update and only if the update has not yet been verified by the MHS SVO. The MHS personnel need to perform a SIT inquiry to verify the Health Insurance Carrier ID of the entry to be cancelled, and ensure that the requested update is still unverified. After ensuring the unverified status of the Health Insurance Carrier ID, the MHS can send the SIT cancellation.

DEERS cancels any OHI policy on the DEERS database associated with the cancelled temporary health insurance carrier. After the update request is cancelled, DEERS does not make the cancelled update request available to all sites holding a local copy of the SIT, or to users with access to the central SIT on DEERS. The cancelled adds or updates are available to the MHS SVO for review as necessary.

1.8.5.   Validation Of Health Insurance Carrier Information

DEERS, provides OASD (HA)/TMA--RM (MC&FS) an application that allows the MHS SVO to validate SIT and allows local sites to request adds and updates to the SIT. In addition, this application can be used by the MHS organizations to query the SIT directly for one of the six actions indicated in paragraph 1.8.

Validation of a SIT update includes verifying the name, mailing address, and telephone number information for the health insurance carrier. In addition, the MHS SVO assigns the Health Insurance Carrier ID to validated health insurance carriers. If the MHS SVO determines that the requested update is not correct, it will be rejected. Rejected updates are only returned to the submitting site.

If a health insurance carrier add request is rejected by the MHS SVO, DEERS terminates any OHI policy on the DEERS database associated with the temporary health insurance carrier. All SIT additions and updates that are validated by the MHS SVO are reported to all systems identified to DEERS as authorized holders of a local copy of the SIT.

1.8.6.   Deactivation of a Health Insurance Carrier

The MHS SVO can also deactivate any health insurance carrier on the SIT. In addition, DEERS deactivates any OHI policy on the DEERS database associated with the deactivated temporary health insurance carrier. DEERS reports the deactivation of the health insurance carrier to all systems identified to DEERS as authorized holders of a local copy of the SIT.

Deactivation can only be done by the MHS SVO. All sites with access to the SIT on DEERS are only able to view the deactivated SIT, as well as the systems identified as authorized holders of a local copy of the SIT.

1.9.   Medicare Data

DEERS performs a match with CMS to obtain Medicare data and incorporates the Medicare data into the DEERS database as OTHER GOVERNMENT PROGRAMS (OGP) entitlement information. This information includes both Medicare A and Medicare B eligibility along with the effective dates. The match includes beneficiaries who are either over or under 65 on the DEERS.

DEERS then sends the Medicare information to the MCSCs. The MCSC sends the information to the Fiscal Intermediaries for identification of Medicare eligibles during claims adjudication.

DEERS sends the MCSC two types of files based on the population of beneficiaries being sent:

- A monthly file including all beneficiaries who will turn 65 within the next 60-90 days and all under 65 beneficiaries declaring Medicare on DEERS within the preceding month.

- Every six months, DEERS sends the MCSC a file of all beneficiaries with Medicare on DEERS.

1.10.   Resource Utilization

1.10.1.   Performance Characteristics

DEERS response times provided in this section are based on internal system response time. Internal system response time is defined as the interval of time from the receipt of the last bit of the incoming transaction to DEERS' communications system until the first bit of the response leaves DEERS' communications system. Communications time is not included in these estimates.

DEERS average response times for online data updates (data push) from socket to socket connections is seven (7) seconds, and for online data queries (data pull) from socket to socket is five (5) to eight (8) seconds.

Average online response time in the current version of DOES is four (4) to six (6) seconds.

Batch transaction response time varies with the batch volume and overall concurrent batches processed.

X12 or HL7 transactions are beyond the scope of these estimates, but are expected to run slower than the batch response times due to the overhead of the translation.